SOUTH-SOUTH SOLIDARITY

SOLIDARITÉ SUD-SUD

SOLIDARIDAD SUR-SUR

南南团结

SOLIDARIDADE SUL-SUL

दक्षिण-दक्षिण एकता

جنوب کی جنوب سے یگانگت

ZUID-ZUID SOLIDARITEIT

Statement

In concurrence with the statements made at the Non-Aligned Conference in Harare in August 1986, the founding members of South-South Solidarity recognize the need to strengthen cooperation among the various states within Asia/Pacific, Africa and Latin America.

Recognizing that there are governmental bodies promoting regional cooperation such as the OAS (Organization of American States), OAU (Organization of African Unity), and SARC (South Asian Regional Cooperation), as well as inter-regional alliances such as the NAM (Non-Aligned Movement), or Group of 77 (UNCTAD), the founding members of South-South Solidarity believe that Non-Government Organisation (NGOs) have an important contribution to make towards enhancing and increasing South-South Cooperation. The areas of exchange among NGOs of Asian, African and Latin American NGOs should include technical assistance, training, public education and information exchange.

These exchanges must take place to engender cooperation and friendship among people of these countries. It is imperative, therefore that NGO cooperation aims to protect the integrity of indigenous development of the people in "the South."

Cover Credit : PAUL
Vancou

Community Health Series
Volume I

Community Health Training in South Asia

-A Report of a Workshop
Held in Bangladesh
MARCH 21-25, 1989.

Produced by:
Jill Carr-Harris
Mukhopadhyay

June 21, 1989

At the cultural evening, the Nepalis were most expressive in their songs and dance.

The whole group

At one of the sessions : Gita from G.K. leads the discussions.

Table of Contents

Bangladesh Workshop on Community Health Training

Introduction

On the high ground of the training hall of Ganashasthya Kendra overlooking peri-urban Dhaka, was the site chosen for the second of the South-South Solidarity sponsored workshops on community health. This time the topic focussed on the requirements for setting up a veritable community health training program. To the discussion came twenty-five participants from four South-Asian states -- many of whom had been at the first of the health meetings in Nepal the year before.

The meeting had been organized in the fashion of a participatory training workshop. Facilitators had been selected by the workship organisers to elicit problem-oriented responses from the group, and based on their experiences, the participants were to challenge each other on the efficacy of their methods, and on whether their programs were working to alter the basic health conditions.

Once the group reviewed each of their programs and made reference to the problems they had with regard to their own organisations and countries, it became self-evident that a single difficulty kept cropping up time and time again--whether the person was from the back-waters of Bangladesh, the hills of Nepal, the plains of India or in the urban slums of Karachi, that is: training are not helping to sustain communiy health programs in the way that they are anticipated that they should. Only in a few instances have people been able to build up a "critical mass" of workers, or trainers, able to change the basic attitudes and behaviour patterns of those people who have little or no access to basic health services.

As one participant remarked at the end of the meeting: "The workshop allowed us to have an outside view on our own activities and experience, and by injecting a certain critical awareness we could internalize some of the lessons of our own practice and learn where we were going wrong".

Owing to the issues that the workshop raised, many of the participants requested South-South Solidarity to review the proceedings in such a way that the process was captured. This would also ensure that in future workshops, we could build on these "learnings". In what follows, we have given a short summary of the main discussion points which I believe is a fair rendition of "the process".

Identifying the Problems

As mentioned earlier, the main feature of the workshop was that its format avoided evoking a ready response. People were called on to give their experiential learning as the substance for the discussion. Here follows is a summary of some the important issues and problems discussed (different speakers represented by a **).

** "This workshop has challenged our basic approach to Primary Health Care" said one participant early in the meeting. "We came here with the expectation of discussing participatory training, but instead we have stepped back to understand the grounds of training and whether it is working".

** Although this method was uncomfortable to many it led to a very significant discussion. "Like the high ball in cricket," said Jill Carr-Harris, a member of South-South Solidarity, "the group like the cricket fielders were taken by surprise. High sounding phrases of 'delivering

health care to all by the year 2000 came down to ground level with a thump! Even the best of the trainers didn't sound very convincing when they began to dissect, and discuss the virtues of their own programs."

** Nazeer Nizamani from the Aga Khan University, Pakistan, began the discussion on training by reminding us what was the substance of the declaration on Primary Health Care given in Alma Ata in 1978. With a careful review of the text it began to be clear to many that the shift in 1978 had been from a health care which supplied medical technologies for the eradication of disease, to one that emphasized "a state of physical mental and spiritual well-being of people." Training in community health had also shifted to a practice of responding to the needs of the local community in a way which develops their self-reliance. This has become the main objective of the trainer -- and medical care was to come second.

** "This is easy to say but difficult to implement," said Mira Shiva of VHAI, India, "We cannot remain suspended at the theoretical level; it is a question of values in action. Community health cannot be a modification of a medical model; but on the other hand when people take up a genuine community health program in the field, they end up by siding with the community against the establishment and the medical profession. One is always in trouble."

** The Pakistan group expressed the same concerns in a different way. They said that health workers were not equipped to deal with the social biases and values in a community. Applying values, based on rational scientific medical grounds, very often clashes with the needs of the community. "How", asked Kamal Islam "does one teach medical students about the socio-cultural and political factors that influence moridity?" "Isn't it true," chorused Islam's colleague, Dr. Thaver, "that we promote these foreign value systems because of the pressures of donors and funders?"

** D.P.Poddar from West Bengal felt that community health was failing owing to the corruption of moral values induced by the government and outside workers, leading to the destruction of indigenous systems of family health care.

** Dr. Samir Chaudhuri brought the blame back to the trainers themselves. "How often do we practise what we preach?" "Isn't it we that have lost touch with the grass-roots because we have become so caugh up in our own institutions?"

Out of this discussion on conflicting value systems between the people and the health workers, it emerged that the frame of reference of the community towards their own health is related to the conditions of injustice, subjugation whereas the frame of reference of the health worker is usually technology-based medical care that gets flanked by the interests of the elites and the international community. By coopting the outside frame of reference onto the local one, leads often to hazardous cnsequences such as corrupt practices which are tantamount to reducing basic health.

** Said Samir Chaudhuri, in response to the exasperation which the whole group felt: "We need to go back to the days of the late 1970's when we discussed the whole concept of community-based training. We have been too interested in finding solutions and as a result, we have got locked into a downward cycle of refining pat methodologies and health management modules, ad nauseum."

** Qasem and Gita of GK were quick to point out that technologies -- health or otherwise do not change fundamental conditions. We simply become stooges for international brokers."

** This led to a moment of confusion where both the Nepali and Pakistani participants who work for international agencies wondered how they could apply this awareness to their own situations. "What if your training institutes do not allow for these inputs?" they asked.

** Whether people work for an international agency or produce information for international agencies, one is in the same dilemma, was the response from the nodal health resource agencies of India (VHAI) and Bangladesh (VHSS).

** GK which maintains a certain level of independence because of political leverage and its scale of funding, expressed the problem in a slightly different way:

"We also find it difficult to alter some of the basic conditions of health," remarked Zafrullah Chowdhury, the director of GK. While the group was watching a video on the recent Bangladesh flood: "How does one help change the basic conditions of a people when their land is being successively ravaged by the scourge of flood and when they have no alternate means of production? GK is continually being reduced to doing famine relief" (i.e. cooking chapatis, distributing ORT packets).

He was quick to add, however, that GK was responding to the futility of this situation by strengthening several agricultural cooperatives in the forthcoming year in which health will be an integral part of the production program.

Such an admission from the director of GK one of South Asia's most prominent health programs made the group -- particularly to those who have been building up large training institutes over the last decades -- feel extraordinarily uncomfortable.

With Zafrullah's recounting of the damage unleashed by the Bangladesh floods, it became evident to all the group that natural forces can undo years of development and health works(s) over night. The Nepali and Indian groups, having adapted health training in the Himalayas, and the Pakistani and Indians in semi-arid regions around the Thar desert, all were in agreement that environmental factors must be an integral part health care and training.

Assessing Training

Each group had already documented the kinds of training program they had set up in their countries. Invariably it was found that they were chalking up large numbers of graduates, rather than working on qualitative learning. This bias in training was due to institutional compulsions. Exceptions to this were the Aga Khan University because of their magnanimous endowment and GK because of its genesis from the freedom movement in Bangladesh.

South-South Solidarity had selected this setting at GK for the deliberations because of the emphasis the organization had put on creating an alternative institutional structure for training. GK became the back-drop against which the group could examine training activities in terms of the importance of some of the following conditions To:

1) Encourage a trainee's development to be able to learn how to link a rational approach to health (development) to the dynamic conditions of a community's development,

2) Development a trainer to be able to sum up day to day learning, to see if they were meeting he socio-economic conditions of development (i.e. have critical awareness),

3) Give a training that would enhance an individual's capabilities and have it respond to their experience rather than following a set formula,

4) Operate a training institute that could forge a collective spirit and reinforce a worker's development, not bending to the pressure of the government or donor agencies.

1) TRAINEES

The group reasoned that one of the main difficulties is that workers' motivation often plummets after a few years because they become more tempted by "careerism," "job mobility" "salaries and perks" rather than by the imperatives of national development.

What GK does, is provide a good learning experience for their young paramedics. GK encourages them to get to know the socio-economic conditions of the village and to have them link their rational (democratic) view of health and development to the conditions of the community.

** Paraphrasing one worker who had been with GK for ten years, he said that he came with he prime motive of getting a job. "However, once I began visiting the village and noting how reluctant people were to treatment, I realized I could not regard my task as a mere 'job'. I also realized the importance of establishing good personal linkages before anything could be done. It took me about three months to gain the confidence of the local people."

He want on to say: "One question which vexed me was whenever I tried to talk about worms, malnutrition or scabies people said they could be cured only through medicines. However, the GK doctors said I should look for local solutions: that medicines were not the answer. Through discussions with the villagers I became aware of how malnutrition was related to economic status, how the lack of family planning was due to the relations of women and men. I came to feel that it was necessary to confer with the village elders and prominent people. I also saw that some of the problems needed political solutions which were beyond my powers. It was perhaps necessary to motivate the people to find political solutions."

"It took one to two years to reach this level of consciousness. I had to be convinced through my own experience. I had to identify political problems as being ones such as the lack of land, leading to no food and hence malnutrition. I got involved in forming cooperatives among the landless where they were encouraged to make a weekly donation of whatever they could afford. There were of course many frustrations. Sometimes vested interests would tell the people that their money would be misappropriated by the health workers and the cooperative would disintegrate. However, discussions with other workers who had faced similar problems kept me going."

This experiential learning of this young health worker describes the kind of attitude that he or she must have to do any kind of meaningful work in the community. The workshop participants felt that this provided a good guideline on how the trainee was to link a rational approach of development to the needs of the community.

2) TRAINER

Since the notion of critical awareness, as the GK worker said, was essential to carrying out village activities, it became evident to the group that critical awareness needed clarification and elaboration for the trainer. The trainer vey often loses the imperative of having critical awareness.

It had already been shown by GK that proper awareness requires that the worker have an understanding of the socio-economic conditions of a designated area in such a way that they can bring a rational (and democratic) understanding to the problems of community's development without losing the sensitivity of the community's perceptions, traditions, needs, etc. This still may not avoid a clash of

value systems (i.e. modern vs. traditional; medical vs. community values). It is necessary for the health worker to minimize this clash by having a:

- disposition towards the people ensuring the people that they determine their own health and development priorities; and

- critical view of medical technologies and the practices of doctors in community development so that the main problems assisted with technology transfer can be avoided.

Critical awareness involves having the openness of learning from the people, in the manner that the GK worker had in the above description. This was demonstrated well by one of the sub-groups. They identified the need to know the social, physical, biological and nutritional factors in the community before establishing the predominance of worm infestation. Their approach was to define the problem as the people perceived it not based on preconceived notions.

The perception of local people may not always be sufficient for the health worker in the course of determining what action to take. For instance when a mother complains of the effects of floods, it is not easy to diagnose a disease and find a package of technological solutions. The preoccupation to diagnose disease needs to be tempered and deemphasized. The important aspect of health work is "the process", and "not the end." The health workers must be trained to work at the rhythm of the people; not to force the peoples to adopt this agenda. Only in this manner can people begin to have control over their own health.

---

* Subgroup B-Day # 3 - Worm Infestation.

People who are doing training do not encourage this. They are too interested in the "fast solutions." and targeted-oriented development, with all the new fangled technologies. This is why it is imperative that the trainer learn critical awareness.

Setting a Long Term Goal

A sense of a process over the long-term is necessary for the trainer to have critical awareness.

Within the workshop we developed a series of pictorial representations to try to capture "the process" of getting critical awareness. As stated previously, critical awareness comes through reflection on one's experience (i.e. experiential learning) and it is a method of overcoming obstacles with a view to achievding a long-term goal.

Suppose we represent our own health work over time, it may be drawn like this.

----------> (goal)
health work

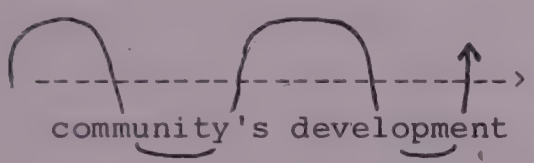
We know that our work is a collective activity in or with a community. Inspite of this we often perceive it as separate from the community.

----------> (goal)
health work

----------> (goal)
community development

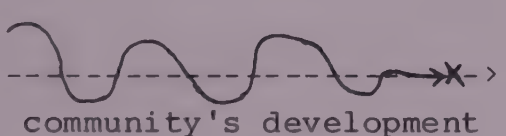
We have said we must know that the socio-economic conditions in order to intersect our health work with the communities development -- may be something like this --

HEALTH WORK



We have also said that we need to be guided by people's perception more than our own learned health science so that our health work will be finally integrated into the community development such that:

HEALTH WORK



At the point (x), health work converges with the community's development. It is visualized that people are able to be more self-reliant depending less on outside interventions. They are able to have more control over their own health and well-being.

These visuals on the formation of a long-term goals, evoked a large response from the group. The earlier discussions had questioned the values related to delivering health care which had exasperated the group. Now it seemed feasible to do health work as an integral part of a community's development, providing the trainer has developed critical awareness which he/she was able to transfer to the health workers and communities.

It was difficult for the group to understand how critical awareness is to be incorporated into a training programer se. As a result the participants were asked to convene into sub-groups and simulate a training to see how far they could apply their own critical awareness.

3) THE TRAINING PROGRAM

Of the three sub-groups convened on the issues of nightblindness, worm infestation and safe-mother-hood, the participants - for the most part, followed this format of training:

1 Identifying the disease (by studying the community);
2 Changing attitudes and behaviour patterns towards health (through education);
3 Taking steps to have community alter public health conditions (i.e. installation of pump for ensuring supply of clean water);
4 Providing treatment (i.e. deworming, etc.); and
5 Reinforcing ongoing preventive health care (through communication materials, etc.).

The group presentations reflected that many of the trainers focussed more attention on how to carry out a training program (formal considerations) rather than on what the substance of the training should consist of (content). This showed the lack of critical awareness within training programs themselves.

This became apparent to many of the participants. When it was discussed is was suggested that many of the training programs are based on predetermined curricula formulated by educators and education administrators (and reflecting conventional values). For instance sometimes we are led to believe:

- that the teacher possess all the know-how;
- tht medical sciences carry the weight of truth; and
- that the optimal conditions for applying a technique or technical device dictates the way things are.

Owing to these biases, it is difficult to evolve a training progrm that is "learner-centered," that builds on "experential learning" and emphasizes "participatory training."

Kamal Islam of AKU, Pakistan, reiterated this when he pointed out that "most curriculum is trainer-led; we need to use a trainee-led approach."

Since few of the participants had themselves developed an alterntive training program, there was some interest to locate a model. It was evident that GK had developed an alternative training method in so far as they linked their training to the institutional arrangements of an 'alternative' organization. Some of the institutional arrangements at GK were that:

- the trainers lived on the campus and they followed certain norms and practices;
- the older workers taught the younger ones;
- the values promulgated by the organization were non-competitive and non-authoritarian;
- gender equality was promoted; and
- emphasis was given to experiential learning and performance.

GK did not seem to currently have an alternative training method per se, that a method is that could be readily adopted in any other organizational settings, rather it provided an alternative institutional framework and ideology in the promotion of health care of which training was an important component.

4) TRAINING INSTITUTE

In the process of evaluating the strengths and weaknesses of GK, it was claimed by the group that critical awareness cannot be built into training programs, unless it is reinforced by institutional arrangements that themselves are "alternative" to the conventional norms (like GK has done).

Of the participating institutions at the workshop who had set up alternative organizations, only VHAI, and VHSS seemed to have institutional arrangements that could be replicated by others doing training. GK however notorious a health organization, its very genesis was more a result of historical circumstances and deft leadership, than it was of planned interventions.

As VHSS had been catalyzed by the founders of VHAI, the group was willing to get an indepth briefing on the method of operation of VHAI and the scope of its activities in India. By reviewing its institutional arrangements, one could see how a training program, and training of traineers, and the development of health workers could be promoted.

Information and Communication Techniques

Another dimension of the discussion on health training was the whole question of using information and communication techniques for building up critical awareness among trainers and health workers alike.

In the earlier discussions recorded above, it was established that a trainer needs to get:

a) information on the socio-economic conditions of a given community so that he/she cn adapt the training method and its content accordingly; and

b) an understanding of the larger 'macro' issues related to health and development so that critical awareness can be achieved and imbued into training programs.

It was also discussed how this kind of training is more likely to occur if alternative institutional arrangements exist to promote the conditions which the government or international agencies rarely do themselves.

To some extent, large nodal voluntary health agencies like VHAI (India) or VHSS (Bangladesh) and the institutes of Community Health of Tribhuven University (Nepal) or Aga Khan University Medical Faculty (Pakistan) have provided alternative institutional arrangements that promote community health training. To what extent they have been able to link information resources to training programs, in such a way as to make the trainers more critically aware, was difficult to determine.

According to the VHAI spokesperson, VHAI has only recently begun to produce materials in local languages that are generated at the field level and redisseminated to grassroot workers. VHSS (Bangladesh) AKU (Pakistan) and TU (Nepal) expressed the obstacles they faced in collecting and producing their own indigenious materials partly owing to the lack of financial resources but also due to the intrusion of information coming from outside agencies--social marketing mateials or otherwise -- which paralyze their local initiatives.

As one participant noted: "Health information is generated at the top-levels and sold at the bottom. Often the health services provided by outside agencies (national and international) have money tagged to the information they produce. Naturally it is biased in their favour."

The group was aware that information on health issues is not value-free and neutral. It was a point of argument, however, how much of the information already produced by outside agencies could be used in the training programs within South-Asia. "This may be a necessary interim step," said one participant in the sub-group discussions, "until we can produce more of our own local variety of health information."

Strengthening the capacities of NGOs to produce alternative information on health for training was an important follow-up activity to be taken up by the workshop participants. It was felt that information generated on NGO experiences could be documented and disseminated if there was a network of like-minded groups in South-Asia, and if mutual support was offered individually or through networks like South-South Solidarity.

Networking

Networking was seen as an essential part of future cooperation among NGOs in South Asia. With this cooperation, it was felt that alternative training strategies and information processing and dissemination could be taken up and promoted.

One of the participants emphasized that a network on health training would develop only if specific exchanges were initiated and builtup over time. In response, South-South Solidarity agreed for its part, that some of the following networking activities could be planned and implemented:

1) Write up the proceedings in such a way that it reflected the importance of "a training process" and altenative training methods.

2) Identify some exchanges tht would further the initiatives of those groups working to incorporate critical awareness into their training and information/ communication activities.

3) Assist specific groups with their information needs.

4) Hold a meeting in 1990 in another South-Asian state on primary health-care on a related topic.

Other exchanges were targetted as well, such as those between Bangladesh and West Bengal, and between South-Asian Nodal Health Agencies.

* See Appendix 3 on recommendations for future networking given by Aga Khan University.

Conclusion

The workshop proceedings were reviewed by all the participants in the final session of the workshop. Of the comments put forward, some of the most striking assessments came from the newcomers to the community health field -- many of them recent graduates from medical schools. They had very much enjoyed staying at the GK campus in spite of their earlier apprehensions, and to have the opportunity of observing GK at close quarters. They felt challenged by some of the discussions at the meeting on such things as the importance of deemphasizing medical care.

They were prepared to try to incorporate some of these new 'learnings' into their programs, and welcomed the formation of a network. For the verterans of the meeting, this was conclusive evidence of a successful workshop.

Appendix 1

List of Participants

Name, address, and Telex Telephone numbers

1.	Amla Rao	VHAI 40 Institutional Area New Delhi-110016	Tel:668071 Fax:011-676377 Gram:VOLHEALTH
2.	Dr. Indrani Ganguly	-do-	-do-
3.	Mr.Jill Carr-Harris	South-South Solidarity P.O. Box 4590 New Delhi-110016	Ph:652466
4.	Samir Chaudhuri	Child in Need Instt.(CINI) Vill:Daulatur, Po:Pailam 24 Parganas-743512 West Bengal	-do-
5.	Dr. Arjun Karki	Po: Box 4650 Kathmandu, Nepal	Tel:410122
6.	Prakash Koirala	Chakupath, POB 992 Lalitput, Nepal	Tel:521576; 521591
7.	Aparna Bhatta	ACTION AID Po:3198, Neaallagımpat, Nepal	Tel:410923; 413027
8.	Dr. Inayat H.	Dept of Community Health Sciences Aga Khan University, Po:3500, Stadium Road, Karachi 74800 Pakistan	Tel:420051-65; Ex.2404
9.	Dr. Naseer Nizamani	-do-	-do-
10.	Dr.Kamal Islam	-do-	-do-
11.	Dr.Moshed Chowdhury	Gonoshasthya Kendra Po:Nayarhat, via. Dhamri Dhaka, Bangladesh	Tel:411567 Telex:675849 GK.DABJ
12.	Nazam Sulttana	Agakhan Foundation 30/1 Purana Pattan, Dhaka, Bangladesh	Tel:406200
13.	Dr. Wahidul Islam	B.R.A.C. 66 Mohokhali, Dhaka-12	Tel: 600161-4

14.	Mr. Santosh Sarkar	Community Health Care Project, Sec.2 Mirpur Housing Estate, Dhaka-1216, Bangladesh	Tel:380685
15.	Dr. Golam Rabbani	BAVS, House 48, Road 4A Dhanmondi Resi. Area Dhaka, Bangladesh.	Tel:505082
16.	Dr.Asim Bhowmik	Comila Proshikha, House 12, Road 12, Dhanmondi/12A, Dhaka, Bangladesh	Tel:311462
17.	Mr.Omar	VHSS, GPOB 4170 273-274, Baital Aman Housing Society, Adabar, Shamoli, Dhaka, Bangladesh.	Tel:319462, 326755
18.	Dr.Mohammed Enamul Kabir	ADAB 1-3 Block F, Dhaka-1207, Bangladesh	Tel:316184 327424
19.	Mr.Tarek Chowdhury Kabir	Proshika Muk 5-2 Iqbal Road Mohammedpur, Dkaha-1207 Bangladesh	Tel:315068-69
20.	Dr.Mohibullah Khondokar	Gonoshasthya Kendra (GK)	
21.	Dr. Tarequl Islam	GK	
22.	Dr. Asadul Haq	GK	
23.	Gita Kar, Director Health	GK	
24.	Mr. Moslem Ali, Asst.Trg.Coordinator	GK	
25.	Dr. Qasem Chowdhury	GK	
26.	Mr. B. Basu	8,Rawdom Street Calcutta 700017	Tel:440019
27.	D.P. Poddar	-do-	-do-

Appendix 2

Contribution by:
Samir Chaudhuri

Dissemination of Information through Networking

All the participants felt tht with so much information that has been forthcoming, some efforts should be made to share this in the immediate future. VHAI was requested to share its evidence on how this has been made possible in India where the national organisation maintains close links with almost 3,000 health NGOs, state and central health departments. This was mind-boggling to friends from neighbouring countries, where the NGO effort in health care is minimal, of course with exceptions such as GK.

VHAI at the national level is collaborating with its state counterpart in almost all the states in India, known as the State Voluntary Health Associations. A specific example of West Bengal Voluntary Health Association (WBVHA) was cited. WBVHA has a membership of over 200 health NGOs in he state of West Bengal and is one of the most active partners of VHAI.

VHAI in New Delhi collects and documents information from different sources on various health issues. These are classified and passed on to the VHA of a state, to be translated into regional languates and adapted for local use. Some recent efforts which have taken the form of movements are anti-tobacco, use of pesticides, food irradiation etc. This information in turn is passed on to member institutions of the states.

In the South-South Solidarity context, this information sharing and networking with members involved with training was considered vital. The participants soon formed themselves into language groups and the best exchange took place between the Bengali speaking groups from India (WBVHA) and their counterpart organisation in Bangladesh the VHSS. It was agreed that periodic exchange of training materials, curriculum as well as exchange of trainers across the borders would go a long way to make networking more effective. Generous offers of local transport and hospitality were accepted when trainers came across the borders to circumvent the exchange restrictions in vogue among countries of the region.

Contribution by:
Aga Khan University

Appendix 3

COMMENTS AND RECOMMENDATIONS
ON WORKSHOP OF TRAINERS
FOR COMMUNITY HEALTH

It was great pleasure for us to participate in this workshop as representatives of the Aga Khan University of Pakistan. It was good to share experiences with participants from four different countries, which included both doctors and non-doctors.

Initially it seemed that the workshop was not proceeding according to tentative schedule, but as time passed on, participants started mixing with each other and exchange of views took place informally outside the seminar room i.e. dinning hall, hostel, teashop. These informal meetings helped participants to participate more actively. There was no barrier between those who were more experienced and those who were less experienced. Often juniors were more encouraged to participate in discussion. Although we could not attend first half day of the workshop during which participants were introduced to each other, we were able in the evening to get acquainted with all participants.

Definition of Health:

One of the participants suggested that health be redefined as "well being of body, mind and soul or physical, mental, social, economical and spiritual well being."

This wash appreciated and a suggestion was made that SSS should take initiative and approach WHO to redefine health case.

It was also suggested that Primary Health Care also be redefined according to the needs and situation in different countries and regions.

Gonoshasthaya Kendro:

It was a great opportunity to stay in GK, and learn about the project while participating in the workshop. The meeting with GK worker was very informative and participants engaged in discussion with them and this helped all participants to study in depth,the work and philosophy of GK.

I was good to see all GK worker getting ready to go to work in agriculture field at 6:00 a.m. and working there for 1 hour and then coming back to usual work (hospital and home visits). The junior and senior, doctors and paramedics, men and women, all were considered GK "Workers" and there was verh high degree of social commitment to induce social change in and around the project. Village women rides, Bicycle, Motorcycle and Cars. They are employed in all

sectors of development including the Carpentry Shop, Printing Press, Bakery, Canteen, Pharmaceutical Industry etc. This project also employees more women than man.

Subgroup discussions

Splitting of participants into three subgroup helped a lot. In subgroups individual participants were involved indiscussion, and there was more learning by the junior participants. Discussion on "Curriculum Development" was thought - provoking and brain storming went on. It generated more interests in partipants and gave opportunity to those participants to speak freely who otherwise were a bit hesitant to speak in relatively big gathering. It was a good exercise to design a curriculum on any given topic, selecting a task and then sub-tasks, and taking into consideration, involvement of trainee and community to develop a curriculum was appreciated by all participants.

Similarly discussion on "Information and Communication" was also discussed in great detail. Varying from methods and types of information, collection, documentation and dissemination, to skill development to alternative approaches were discussed.

Networking

The idea of networking among NGOs of the four countries as well as Sri Lanka was welcomed by all participants.

Suggestions/Recommendations

1. A report on workshop be prepared and distributed to all participants.

2. Networking should begin with exchange and available information on "training." South-South Solidariy should play an active part in facilitating this process.

3. All participating NGOS, were instructed to inform about their training activities in future, and if possible participants from other countries be encouraged to participate in it.

4. After looking at the future plan of SSS. It is observed that Pakistan is not included in your future plans, and Pakistan is also not represented at the membership level of SSS. More NGOs be invited from Pakistan to participate in future activities of SSS.

5. Regarding arranging next meeting in Pakistan (as suggested by Jill), SSS should contact chairman of department of Community Health Sciences, Aga Khan University to facilitate holding the next SSS meeting in Pakistan.

J S Bros., A-30/1, Naraina Industrial Area
Phase-I. New Delhi-110028 □ Ph. : 536533

Founding Members of South-South Solidarity

Mr. Mazide N'Diaye
Director
African Network in Development
(ANID/RADI)
Gibraltar II. No 282
B.P. 12085
Dakar, Senegal

Dr. Samir Choudhury
Child-in-Need Institute (CINI)
Vill. Daulatpur, PO: Amgachi
Via : Joka - 743 512
24 Parganas, West Bengal
India

Ms. Rokiatou Tall
Secretaire Executive
Association pour la Formation en
Technologies Appropriate dans le
Sahel (AFOTEC)
Villa 8297 - Sacre Coeur I
Dakar, Senegal

Ms. Ela R. Bhat
Self Employed Womens Association (SEWA)
Reception Centre
Opp. Victoria Gardens
Ahmedabad-380 001
India

Mr. Paul Wangoola
Programme Director
African Association for
Literacy and Adult Education
(AALAE)
BP Box 50768
Nairobi, Kenya

Mr. Alok Mukhopadhyay
Voluntary Health Association of
India (VHAI)
(Near Qutab Hotel), South of
I.I.T.
New Delhi-110 016
India

Dr. B.V. Parameswara Rao
The Bhagavatula Charitable Trust
(BCT)
Yellamanchili - 531 055
Visakhapatnam District
Andhra Pradesh, India

Dr. J.B. Singh
Action for Food Production
(AFPRO)
25/1A Institutional Area,
Pankha Road, D-Block, Janakpuri
New Delhi-110 058
India

Dr. Zafrullah Chowdhury
Project Coordinator
Ganoshasthaya Kendra (GK)
PO : Nayarhat, Via Dhamrai
Dhaka, Bangladesh

Ms. Jill Carr-Harris
Honorary Programme Officer
South-South Solidarity (3S), c/o
VHAI
40, Institutional Area
(Near Qutab Hotel), South of
I.I.T.
New Delhi-110 016
India

South-South Solidarity
Post Box No. 4590
New Delhi-110016
India